

CHAPTER 45-08-02
GROUP COVERAGE DISCONTINUANCE AND REPLACEMENT MODEL
REGULATION

Section	
45-08-02-01	Scope
45-08-02-02	Definitions
45-08-02-03	Unfair Discrimination in Group Health Insurance Coverage Transfers
45-08-02-04	Effective Date of Discontinuance for Nonpayment of Premium or Subscription Charges
45-08-02-05	Requirements for Notice of Discontinuance
45-08-02-06	Extension of Benefits
45-08-02-07	Continuance of Coverage in Situations Involving Replacement of One Carrier by Another

45-08-02-01. Scope. This chapter is applicable to all insurance policies and certificates and subscriber contracts issued or provided by an insurance company, health maintenance organization, or a nonprofit service corporation on a group or group-type basis covering persons as employees of employers or as members of unions or associations.

History: Effective March 1, 1988.

General Authority: NDCC 26.1-04-08, 28-32-02

Law Implemented: NDCC 26.1-04-03(7), 26.1-30-19, 26.1-33-11, 26.1-33-12, 26.1-36-22, 26.1-36-23, 26.1-36-23.1

45-08-02-02. Definitions. For purposes of this chapter:

1. "Carrier" means a person or an entity that offers or provides a policy, contract, or certificate of insurance coverage in this state. "Carrier" includes an insurer, a health maintenance organization, a nonprofit service corporation, or any other person or entity providing a policy, contract, or certificate of insurance coverage subject to state insurance regulation.
2. "Group-type basis" means a benefit plan, other than "salary budget" plans utilizing individual insurance policies, certificates, or subscriber contracts, which meets the following conditions:
 - a. Coverage is provided through insurance policies, certificates, or subscriber contracts to classes of employees or members defined in terms of conditions pertaining to employment or membership.
 - b. The coverage is not available to the general public and can be obtained and maintained only because of the covered person's membership in or connection with the particular organization or group, including bank depositor groups.

- c. There are arrangements for bulk payment of premiums or subscription charges to the insurer or nonprofit service corporation.
 - d. There is sponsorship of the plan by the employer, union, bank, or association.
3. a. "Health insurance coverage" means a hospital and medical expense incurred policy, a nonprofit health care service plan contract, a health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.
- b. "Health insurance coverage" shall not include one or more, or any combination of, the following:
- (1) Coverage only for accident, or disability income insurance, or any combination thereof;
 - (2) Coverage issued as a supplement to liability insurance;
 - (3) Liability insurance, including general liability insurance and automobile liability insurance;
 - (4) Workers' compensation or similar insurance;
 - (5) Automobile medical payment insurance;
 - (6) Credit-only insurance;
 - (7) Coverage for onsite medical clinics; and
 - (8) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) [Pub. L. No. 104-191], under which benefits for medical care are secondary or incidental to other insurance benefits.
- c. "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:
- (1) Limited scope dental or vision benefits;
 - (2) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
 - (3) Other similar, limited benefits specified in federal regulations issued pursuant to HIPAA.

- d. "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:
 - (1) Coverage only for a specified disease or illness; or
 - (2) Hospital indemnity or other fixed indemnity insurance.
- e. "Health insurance coverage" shall not include the following if offered as a separate policy, certificate, or contract of insurance:
 - (1) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
 - (2) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code; or
 - (3) Similar supplemental coverage provided to coverage under a group health plan.

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General Authority: NDCC 26.1-04-08, 28-32-02

Law Implemented: NDCC 26.1-04-03(7), 26.1-30-19, 26.1-33-11, 26.1-33-12, 26.1-36-22, 26.1-36-23, 26.1-36-23.1

45-08-02-03. Unfair discrimination in group health insurance coverage transfers. Group coverage of accident and health insurance benefits transferred from one carrier to another must guaranty transfer of coverage for all eligible persons covered under the existing group insurance program and the transfer of such coverage must be negotiated on the basis of all eligible persons being covered under the group insurance program of the new carrier, irrespective of the current state of health of such persons, provided all such persons are currently covered under the present carrier's group insurance program. Violation of this section by an insurance company or agent constitutes unfair discrimination and is a prohibited practice as defined in subsection 7 of North Dakota Century Code section 26.1-04-03.

History: Effective March 1, 1988.

General Authority: NDCC 26.1-04-08, 28-32-02

Law Implemented: NDCC 26.1-04-03(7), 26.1-30-19, 26.1-33-11, 26.1-33-12, 26.1-36-22, 26.1-36-23, 26.1-36-23.1

45-08-02-04. Effective date of discontinuance for nonpayment of premium or subscription charges.

1. If a policy or contract or certificate subject to these rules provides for automatic discontinuance of the coverage after a premium or subscription charge has remained unpaid through the grace period allowed for such payment, the carrier is liable for valid claims for covered losses incurred prior to the end of the grace period.
2. If the actions of the carrier after the end of the grace period indicate that it considers the coverage as continuing in force beyond the end of the grace period (such as, by continuing to recognize claims subsequently incurred), the carrier is liable for valid claims for losses beginning prior to the effective date of written notice of discontinuance to the policyholder or other entity responsible for making payments or submitting subscription charges to the carrier. The effective date of discontinuance shall not be prior to midnight at the end of the third scheduled workday after the date upon which the notice is delivered.

History: Effective March 1, 1988.

General Authority: NDCC 26.1-04-08, 28-32-02

Law Implemented: NDCC 26.1-04-03(7), 26.1-30-19, 26.1-33-11, 26.1-33-12, 26.1-36-22, 26.1-36-23, 26.1-36-23.1

45-08-02-05. Requirements for notice of discontinuance.

1. Any notice of discontinuance so given by the carrier must include a request to the group policyholder or other entity involved to notify employees covered under the policy or subscriber contract of the date as of which the group policy or contract will discontinue and to advise that, unless otherwise provided in the policy, certificate, or contract, the carrier shall not be liable for claims for losses incurred after such date. Such notice of discontinuance must also advise, in any instance in which the plan involves employee contributions, that if the policyholder or in any instance in which the plan involves employee contributions, that if the policyholder or other entity continues to collect contributions for the coverage beyond the date of discontinuance, the policyholder or other entity may be held solely liable for the benefits with respect to which the contributions have been collected.
2. The carrier will prepare and furnish to the policyholder or other entity at the same time a supply of a notice form to be distributed to the employees or members concerned indicating such discontinuance and the effective date thereof, and urging the employees or members to

refer to their certificates or contracts in order to determine what rights, if any, are available to them upon such discontinuance.

History: Effective March 1, 1988.

General Authority: NDCC 26.1-04-08, 28-32-02

Law Implemented: NDCC 26.1-04-03(7), 26.1-30-19, 26.1-33-11, 26.1-33-12, 26.1-36-22, 26.1-36-23, 26.1-36-23.1

45-08-02-06. Extension of benefits.

1. Every group policy or certificate or other contract subject to these rules hereafter issued, or under which the level of benefits is hereafter altered, modified, or amended, must provide a reasonable provision for extension of benefits in the event of total disability at the date of discontinuance of the group coverage, as required by the following subsections.
2. In the case of a group life plan which contains a disability benefit extension of any type (e.g., premium waiver extension, extended death benefit in event of total disability, or payment of income for a specified period during total disability), the discontinuance of the group policy does not operate to terminate such extension.
3. In the case of a group plan providing benefits for loss of time from work or specific indemnity during hospital confinement, discontinuance of the policy during a disability has no effect on benefits payable for that disability or confinement.
4. In the case of hospital or medical expense coverages other than dental and maternity expense, a reasonable extension of benefits or accrued liability provision is required. Such a provision will be considered "reasonable" if it provides an extension of at least twelve months under "major medical" and "comprehensive medical" type coverages, and under other types of hospital or medical expense coverages provides either an extension of at least ninety days or an accrued liability for expenses incurred during a period of disability or during a period of at least ninety days starting with a specific event which occurred while coverage was in force (e.g., an accident).
5. Any applicable extension of benefits or accrued liability must be described in any policy or contract involved as well as in group insurance certificates. The benefits payable during any period of extension or accrued liability may be subject to the policy's or contract's regular benefit limits (e.g., benefits ceasing at exhaustion of a benefit period or of maximum benefits). For hospital or medical

expense coverages, the benefit payments may be limited to payments applicable to the disabling condition only.

History: Effective March 1, 1988; amended effective March 1, 2004.

General Authority: NDCC 26.1-04-08, 28-32-02

Law Implemented: NDCC 26.1-04-03(7), 26.1-30-19, 26.1-33-11, 26.1-33-12, 26.1-36-22, 26.1-36-23, 26.1-36-23.1

45-08-02-07. Continuance of coverage in situations involving replacement of one carrier by another.

1. This section shall indicate the carrier responsible for liability in those instances in which one carrier's (succeeding carrier) contract replaces a plan of similar benefits of another (prior contract).
2. Liability of prior carrier. The prior carrier remains liable only to the extent of its accrued liabilities and extensions of benefits. The position of the prior carrier is the same whether the group policyholder or other entity secures replacement coverage from a new carrier, self-insures, or foregoes the provision of coverage.
3. Liability of succeeding carrier.
 - a. (1) If the individual was validly covered under the prior plan on the date of discontinuance, each individual who is eligible for coverage in accordance with the succeeding carrier's plan of benefits with respect to the class or classes of individuals eligible for coverage under the succeeding carrier's plan and any actively-at-work and nonconfinement rules and requests enrollment shall be enrolled and covered by the succeeding carrier's plan of benefits.
 - (2) In the case of health insurance coverage:
 - (a) A succeeding carrier shall not have any nonconfinement rules in its plan of benefits; and
 - (b) Any actively-at-work rules provided in the succeeding carrier's plan of benefits shall provide that absence from work due to any health status-related factor be treated as being actively at work.
 - (3) For purposes of this paragraph, "health status-related factor" means any of the following factors:
 - (a) Health status;

- (b) Medical condition, including both physical and mental illnesses;
 - (c) Claims experience;
 - (d) Receipt of health care;
 - (e) Medical history;
 - (f) Genetic information;
 - (g) Evidence of insurability, including conditions arising out of acts of domestic violence; or
 - (h) Disability.
- b. Each person not covered under the succeeding carrier's plan of benefits in accordance with subdivision a must nevertheless be covered by the succeeding carrier in accordance with the following rules if such individual was validly covered (including benefit extension) under the prior plan on the date of discontinuance. Any reference in the following rules to an individual who was or was not totally disabled is a reference to the individual's status immediately prior to the date the succeeding carrier's coverage becomes effective.
- (1) The minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits payable by the prior plan.
 - (2) Coverage must be provided by the succeeding carrier until at least the earliest of the following dates:
 - (a) The date the individual becomes eligible under the succeeding carrier's plan as described in subdivision a.
 - (b) For each type of coverage, the date the individual's coverage would terminate in accordance with the succeeding carrier's plan provisions applicable to individual termination of coverage (e.g., at termination of employment or ceasing to be eligible dependent, as the case may be).
 - (c) In the case of an individual who was totally disabled, and in the case of a type of coverage for which section 45-08-02-06 requires an extension of accrued liability, the end of any period of extension or accrued liability which is required of the prior carrier by section

45-08-02-06 or, if the prior carrier's policy or contract is not subject to that section, would have been required of that carrier had its policy or contract been subject to section 45-08-02-06 at the time the prior plan was discontinued and replaced by the succeeding carrier's plan.

- c. For health insurance coverage, in the case of an individual who was totally disabled at the time the prior carrier's plan was discontinued and replaced by the succeeding carrier's plan, and in the case in which section 45-08-02-06 requires an extension of benefits or accrued liability, the minimum level of benefits to be provided by the succeeding carrier shall be the applicable level of benefits of the prior carrier's plan reduced by any benefits paid by the prior plan.
- d. In the case of a preexisting conditions limitation included in the succeeding carrier's plan, the level of benefits applicable to preexisting conditions of persons becoming covered by the succeeding carrier's plan in accordance with this subsection during the period of time this limitation applies under the new plan shall be the lessor of:
 - (1) The benefits of the new plan determined without application of the preexisting conditions limitation; and
 - (2) The benefits of the prior plan.
- e. The succeeding carrier, in applying any deductibles or coinsurance amounts applicable to the out-of-pocket maximums or waiting periods in its plan, shall give credit for the satisfaction or partial satisfaction of the same or similar provisions under a prior plan providing similar benefits. In the case of deductible provisions or coinsurance amounts applicable to the out-of-pocket maximums, the credit shall apply for the same or overlapping benefits periods and must be given for expenses actually incurred and applied against the deductible or coinsurance provisions of the prior carrier's plan during the ninety days preceding the effective date of the succeeding carrier's plan but only to the extent these expenses are recognized under the terms of the succeeding carrier's plan and are subject to similar deductible or coinsurance provision.
- f. In any situation where a determination of the prior carrier's benefit is required by the succeeding carrier, at the succeeding carrier's request the prior carrier shall furnish a statement of the benefits available or pertinent information, sufficient to permit verification of the benefit determination or the determination itself by the succeeding carrier. For the purposes of this section, benefits of the prior plan will be determined in accordance with all of the

definitions, conditions, and covered expense provisions of the prior plan rather than those of the succeeding plan. The benefit determination will be made as if coverage had not been replaced by the succeeding carrier.

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